Person Centered Planning Commission Workgroup

Feb 12, 2009

Present: Michael Lee, Kiana Harrison, Cian Eppelheimer, Marsha Ellis, Tricia Harney, Tiffaney Romelus, Amy Pisoni, Michelle Mull, Michelle Johnson, Chris Hennessy, Andy farmer, Brenda Roberts, Wendi Middleton, Michelle McGuire, Cynthis Farrell, Tari Muniz, Denise Rabidoux, Nora Barkey

Handouts: Agenda; Person Centered Planning (PCP)Across the Array: Core Elements and Implementation Plan; PCP Statements and Requirements in Existing Policy/Rules Chart, Minutes October 22, 2008, Logic Model Planning Document

Meeting Notes: Everyone was welcomed to the meeting. Special thanks to Wendi Middleton from the Office of Services to the Aging for hosting the meeting.

Welcome and Purpose

Nora reviewed the purpose of today's meeting which is to share and update the group on recent work; to review the definition, core values and essential elements document; to make a recommendation to the Commission on person centered planning process for use by the state of Michigan; and to continue planning using the logic model format—this plan will guide work related to Recommendation One of the Commission, its workgroups and the OLTCSS.

The co-chairs of the workgroup, Dohn Hoyle and Denise Rabidoux, together with staff from the Office of Long Term Care Supports and Services, and in conjunction with the Commission/Office Retreat have been meeting since the October develop a process to support the PCP Commission work group's previous efforts and to create a framework for increasing activity across the array of services.

Background

Important but incremental work has been occurring, including:

> Meetings and discussion to increase understanding of person centered planning processes and how they can be implemented in nursing homes has been the focus of several sub committees.
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> The MI Choice Waiver program incorporated new standards related to PCP and several rounds of training have occurred.
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> The Long Term Care Connection's standards and staff training for Information and Assistance and Options Counselors focus on creating agencies that understand and provide PCP.
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> The Office of Service to Aging provided training to AAA Care Managers, AAA waiver agents and to Information and Assistance staff.
>
> The Department of Human Services has hired a new trainer who will be working with this workgroup to become more familiar with PCP elements and training materials as she plans for new training for Adult Service workers.

Our logic model plan

We discussed the objectives in the draft logic model plan and planned specific activities that will be added to the plan and guide our time and actions so we can reach the outcomes. See attached revised "logic model plan".

Activities planned for the next several months focus on sharing the definition, values and elements to seek broader stakeholder support. We will seek association and institutional involvement in incorporating the values and elements and work together to impact communication and interactions, service and to increase control and choice for individuals.

The logic model plan includes a reference to the "PAT". The OLTCSS has created project action teams (PATs) for each of the nine Task Force Recommendations. A staff member is identified as the "lead" and that person has responsibility to coordinate and document the planning process using the logic model template. Where there is a Commission work group the "lead" will attend and assist with communication. If you want more information about the PAT members, a list is attached. Nora and Tari are working together to assist the PCP effort. Tari provided a great deal of help with identifying outcomes and measures and will be working with the Training subcommittee.

The need to partner with other Commission workgroups was highlighted and we will work with Public Education and Quality Management work groups. We will join with the Public Education Workgroup and others to incorporate awareness and understanding of person centered planning in a broad based campaign to help Michigan residents understand and plan for long term care needs and for the state of Michigan to make the changes. We will meet with the QM group to provide the definition, values and elements so that QM activity can plan ways to measure progress across the array and assure that persons who use long term care services have the control and choice they desire.

A subcommittee will convene to continue the work so that curriculum and training opportunities are congruent with the values and elements and are available across the array. It was agreed that involving additional persons who represent the university and profession disciplines is essential if these values are to be incorporated into standards of practice across disciplines and the array.

The logic model plan identifies individuals who have volunteered to be part of making this happen.

Finally, there was discussion about the importance of having funds to support this work. Several ideas were identified and this will be a standing agenda item. If our plans and products are good, if we have involvement and support from stakeholders we will attract the administrative, legislative and other support and funds needed.

Recommendation Vote

The group reviewed the definition, core values and essential elements which are provided at the end of these minutes and also part of the "Person-Centered Planning Across the Array Core Elements and Implementation Plan January 28, 2009 Document."

Identifying, supporting and implementing the person centered planning definition and using the core values and essential elements across the array will result in improvements in communication, control, and decision making provided to Michigan residents who are using long term care supports. Michigan providers and policy makers will have a common understanding of person centered planning processes.

The public, providers and policy makers will be better able to understand and work together to make person centered planning process a reality which ensures a strength focus resulting in plans that support the individuals own goals and preferences.

Motion:

We ask that the Commission support and recommend that the state adopt the definition, values and essential elements as written in **"Person-Centered Planning Across the Array Core Elements and Implementation Plan January 28, 2009 Document."** as an essential step to achieve TF Recommendation One.

Vote: unanimous support.

Andy, Denise and Dohn, will take the motion to the March meeting.

Definition, Core Values/Principles and Essential Elements

Definition

"Person-Centered Planning" means a process for planning and supporting the consumer receiving services that builds on the individual's capacity to engage in activities that promote community life and that honors the consumer's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the consumer desires or requires. (PA 634 **Sec. 109i** (23) f)

Core Values and Principles

The Person-Centered Planning process is based on the following values and principles:

- Person-Centered Planning is an individualized process designed to respond to the preferences and desires of the individual.
- The person and (if desired) people important to him or her are included in planning.
- Each individual has strengths and the ability to express preferences and make choices.
- The individual's choices and preferences shall always be honored and considered.
- The person uses, when desired and available natural and community supports.
- Each individual can contribute to the community, and has the ability to choose how supports and services may help them meaningfully participate in and contribute to the community.

- Person-Centered Planning processes maximize independence, create or maintain community connections, and work towards achieving the individual's dreams, goals, and desires.
- A person's cultural background shall be recognized and valued in the planning process.
- The planning process is supportive of the person and their wishes, collaborative, reoccurring and involves an ongoing commitment to the whole person.

Essential Elements

The Person-Centered Planning process includes the following:

- *Person-Directed.* The individual controls the planning process.
- *Capacity Building.* Planning focuses on an individual's gifts, abilities, talents, and skills rather than deficits.
- *Person-Centered.* The focus is continually on the individual's life with whom the plan is being developed and not on fitting the person into available services and supports in a standard program.
- *Outcome-Based.* The planning process focuses on increasing the experiences identified as valuable by the individual during the planning process.
- *Presumed Competence.* All individuals are presumed to have the capacity to actively participate in the planning process (even individuals with cognitive and/or mental disabilities are presumed to have capacity to participate).
- *Information.* A PCP approach must address the individual's need for information, guidance, and support.
- *Facilitation.* Individuals may choose to have an independent advocate/champion to act as facilitator. Facilitation may include pre-planning and conducting the planning meetings. This may be done more effectively by someone outside of the provider organization
- *Participation of Allies.* For most individuals, person-centered planning relies on the participation of allies chosen by the individual, based on whom they feel is important to be there to support them.
- *Health and Welfare.* The needs of the individual must be addressed in a person centered manor, strategies to address identified health and welfare needs are supported to allow the individual to maintain his/her life in the setting of his/her choice.
- *Documentation.* The planning results should be documented in ways that are meaningful to the individual and useful to people with responsibilities for implementing the plan.

We appreciate all who participated today and look forward to hard work, fun and the satisfaction of knowing that changes will occur for workers; for persons using long term care supports and/or services; and for family and friends resulting in increased satisfaction, achievement of individual goals and quality of life.